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TECHNIQUES AND PROCEDURES

Nitrogen Balance Studies in Clinical Nutrition

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ABSTRACT: Nutrition support is recognized as an important cofactor in altering morbidity and mortality of hospitalized patients. Paramount in delivering proper nutrition support is the accurate determination of baseline metabolic and nutritional status, thus influencing necessary protein requirements. After nutritional intervention, routine laboratory monitoring is used to measure the efficacy and to reassess metabolic stress level. Accurate determination of nitrogen excretion (and nitrogen balance) remains the standard in prescribing and monitoring the protein and nutritional treatment regimen. This article examines nitrogen excretion determinations in the clinical setting, including proper collection techniques, laboratory measurements, and analyses and their effect upon nitrogen balance studies.

Although the history of enteral feeding dates back to the ancient Greeks and Egyptians, advances in scientific knowledge and technology of modern clinical nutrition have evolved only within the past 25 years.¹ Dr Stanley J. Dudrick and his colleagues performed their famous animal study in 1968 in which the total nutritional needs of beagle puppies were adequately supported by parenteral administration.² Protein, fat, and carbohydrate levels were supported in the puppies, and they developed in similar fashion to their counterparts that were allowed to eat ad lib from a comparable menu. The principles of this animal study were soon applied in the case of a young girl unable to ingest food on her own. Similar results were observed and recorded in this case.³ Nutrition support is used in many hospitalized patients. It is now recognized that nutrition support, if properly administered and carefully monitored, can safely and effectively support protein synthesis in humans, resulting in positive nitrogen balance. Nutrition support cannot halt the catabolic process induced by the neurohumorally mediated metabolic stress response accompanying trauma, surgery, or burn inju-

ries. It supplements the raw materials of anabolism in support of new proteins for wound healing and immune response.

Both standard enteral and parenteral formulas are marketed for patients, and depending upon disease- or organ-specific requirements, specialized formulas (eg, branched-chain amino acid formulas, liver failure formulas) have also become available. New formulas continue to be developed such as one containing arginine, ribonucleic acids, and omega-3 and omega-6 fatty acids, which have been shown to have a positive effect on immune function.⁴

Nutrition support is now perceived to enhance patients' preparation for surgery as well as strengthen their prescribed program of postoperative care. A connection linking perioperative nutrition support to decreased morbidity, mortality, and length of stay in the hospital is thought to exist.

To properly determine individual nutritional demands, a thorough patient evaluation must be conducted.⁵⁻⁸ The evaluation can be classified into three parts. First, a medical history and physical examination including body measurements are needed. Next, chemistry panels including visceral protein markers and immunologic tests are made. Last, urine studies of the patient should be undertaken. These include nitrogen balance assessment and the determination of the creatinine height index.

Although all three facets of nutrition assessment play an important part in evaluating patient nutriture, only the urine indices required to calculate nitrogen losses and skeletal muscle mass will be addressed in this article. The nitrogen losses determined from a 24-hour urine collection with protein (nitrogen) input enable the calculation of respective nitrogen balance. Protein requirements and the efficacy of nutrition therapies may be determined from the nitrogen balance calculation. When one measures urine creatinine losses, estimates for skeletal muscle mass can be derived.⁹⁻¹¹

This article reviews nitrogen balance studies and provides a definition of nitrogen balance and information regarding proper collection techniques, laboratory measurements, and analytical procedures. Finally, the

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interpretation of nitrogen balance is addressed as it is used with other clinical parameters and sound clinical judgment in determining protein requirements.

COMPONENTS USED IN NITROGEN BALANCE STUDIES

Nitrogen balance is equal to nitrogen output subtracted from nitrogen input. A negative nitrogen balance indicates a condition, such as trauma, burn, or surgery, in which the rate of protein catabolism exceeds the rate of protein anabolism. A positive nitrogen balance is indicative of nitrogen retention, such as in pregnancy. When adjusted for changes in weight and blood urea nitrogen, positive nitrogen balance generally correlates with net protein synthesis.

Nitrogen input can easily be calculated using the relationship of protein ingested divided by 6.25, when patients are receiving a standard hospital diet. Adjustments in nitrogen values must be made for modified amino acid formulas when total parenteral nutrition (TPN) or total enteral nutrition (TEN) is used. When patients are supplemented or transferred to oral feedings, careful monitoring must be performed to accurately quantify nitrogen input.

Absolute nitrogen output determination requires the measurement of nitrogen content from bodily excretion including urine, feces, sweat, and dermal tissue. Because of the difficulties associated with the collection of waste products, urine and feces are the most commonly collected samples used to calculate nitrogen loss. In unstressed persons, 80% to 90% of the urinary nitrogen loss can be accounted for by urinary urea nitrogen (UUN).^{5,7,8,12} Because of its relative ease, low laboratory cost, and rapid turnaround time, UUN analysis is often substituted for measured TUNs. The

validity of this practice in the hospitalized patient will be addressed in a later section. The measured UUN is increased by 25% to account for the nonurea component of the urine, and another factor is usually added to account for nitrogen losses through stool and skin. This factor varies depending upon the individual's level of stress, diarrhea, and other variables. Burn patients have an additional, equivalent amount proportional to burn size for burn wound nitrogen losses.¹³ Interinstitutional variations in adjustment factors are common practice, but these variations will alter the reliability of nitrogen balance determinations. Each institution should develop its own standard for adjustment factors. Compliance in evaluation techniques, within nutrition support teams, must occur in order to provide valid daily nutritional assessment.

EFFECT OF SAMPLE TEMPERATURE DURING COLLECTION AND STORAGE

Many standard texts suggest that 24-hour urine specimens for nitrogen excretion tests be kept on ice, followed by refrigeration. It is unclear whether the use of ice constitutes unnecessary time and expense. Several studies have been done involving temperature and its influence on the analysis of urine. Konstantinides et al addressed the issue of storing urine on ice in a study that involved 24-hour urine collections from 29 catheterized intensive care unit patients.^{14,15} They concluded that neither sterile nor unsterile samples need to be kept on ice, thereby eliminating the inconvenience of iced collection in the clinical setting (Table 1).

Zlatnik conducted a study calculating the UUN ratios among 10 women with uncomplicated pregnancies.¹⁶ He also addressed storage effects on the urine. Samples were refrigerated and reanalyzed 7 to 10 days

Table 1. Test results from 24-hour urines collected on ice (cold) versus collected at room temperature (warm) for urinary urea nitrogen, total urinary nitrogen, and creatinine*

	Group I Sterile (n = 18)	Group II Bacteria (n = 7)	Group III Yeast (n = 4)
Urinary urea nitrogen			
Warm mean \pm SD	12.04 \pm 7.02	12.04 \pm 6.61	17.25 \pm 13.08
Cold mean \pm SD	12.03 \pm 7.28	11.80 \pm 6.11	17.16 \pm 12.99
Standard values \pm SE	101.08 \pm 1.41	100.85 \pm 3.62	99.92 \pm 1.47
Correlation coefficient	0.99	0.99	0.99
Total urea nitrogen			
Warm mean \pm SD	15.49 \pm 8.62	14.90 \pm 7.00	22.08 \pm 16.09
Cold mean \pm SD	15.67 \pm 8.71	14.90 \pm 7.28	22.08 \pm 16.29
Standard values \pm SE	98.59 \pm 1.09	101.08 \pm 2.09	100.28 \pm 0.53
Correlation coefficient	0.99	0.99	0.99
Creatinine			
Warm mean \pm SD	1.05 \pm 0.98	1.02 \pm 0.55	1.20 \pm 0.34
Cold mean \pm SD	1.05 \pm 1.01	1.04 \pm 0.58	1.22 \pm 0.3
Standard values \pm SE	102.25 \pm 2.6	97.81 \pm 2.48	103.64 \pm 4.38
Correlation coefficient	0.99	0.99	0.99

* All results are given in g/24 h collection. Reprinted with permission from Konstantinides et al.¹⁴

after collection. Interassay variations were minimal. It was concluded that after refrigeration, stored urine samples remain stable for analysis. Konstantinides et al also addressed the storage of frozen urine for later assessment of nitrogen balance.¹⁷ Fifty-five paired samples were obtained from intensive care unit patients. One aliquot was analyzed soon after collection, and the other was frozen and analyzed 15 months after the first. They concluded that frozen storage of samples did not significantly affect the analysis of urine.

PRESERVATIVES

Methods of preserving urine specimens can alter the values of substances in the urine used for nutrition assessment. Konstantinides et al addressed this issue in a prospective multi-armed study performed on 11 surgical/trauma patients during the acute phase of illness.¹⁵ Twenty-four-hour urine samples were collected by free-flowing catheters. The urine collection bags were emptied every 1 to 2 hours or as deemed necessary by staff nurses. Voiding was measured by laboratory personnel, and urine was immediately transferred to collection vessels containing EDTA-sodium metabisulfite, HCl, or no preservative. These procedures were continued for a 24-hour period, at which time the no-preservative aliquot was subdivided and 6 N HCl was added to half of the aliquot until a pH of 3.0 was obtained. No significant differences were detected among the four collection techniques for TUN, UUN, or creatinine. The average standard deviation for each sample measured for UUN, TUN, and creatinine were ± 1.57 , ± 0.80 and ± 0.12 g per collection, respectively.¹⁵ These data suggest that when 24-hour urine is collected for assessment (TUN, UUN, or creatinine) and treatment efficacy, preservative is not required.

PARTIAL VERSUS 24-HOUR COLLECTIONS

The issue of timed urine collections has been discussed by several authors¹⁸⁻²³ (Table 2). Twenty-four-hour urine provides the most accurate results but is inconvenient to obtain. Shorter collection periods allow a more rapid assessment of the patient's nutritional requirements and are easier to obtain. Nitrogen balance can be calculated the same day, and nutrition therapy can be implemented immediately. Although a shorter collection period can be representative of a 24-hour period, it can depend on the correlation of many variables.

Quandt et al, Record et al, and Candio et al have determined that shorter collection periods are acceptable substitutes for 24-hour collection if the nutrition rate is kept constant.¹⁸⁻²⁰ This is especially ironic because calculation of nitrogen balance itself is a chief determinant of the nutritional state of the patient. Ford et al and Lopez et al stress the need for 24-hour collections for nutritional therapy.^{21,22} Although there are certain advantages of the shorter collection periods, 24-hour urine collections are the most accurate way of determining nitrogen balance. In the highly stressed patient it may be more accurate to take sequential 24-hour collections and average them over several days.

VALIDITY OF MEASURING UUN AS A SUBSTITUTE FOR TUN

Investigators have shown that urea comprises 80% of the TUN in healthy, nonstressed surgical patients.^{5,7,8,12} Others have demonstrated that this percent varies widely depending upon the degree of stress, disease state, or course of illness²⁴⁻³² (K. Boehm, personal communication) (Table 3). Part of the altered

Table 2. Partial versus 24-h urine collections in hospitalized patients*

Author/Ref. no.	Year	No. of Subjects	Age	Subjects	Time	Conclusion	Comments
Candio et al ¹⁸	1991	56		Critically ill	4, 8, 12 versus 24 h	4, 8 h, poor; 12 h, acceptable	Addresses bias, scaling
Ford et al ²¹	1987	6	8 mo to 13 y	Severely stressed	4, 8 versus 24 h	Need 24 h	
Lopez et al ²²	1986	15	2 wk to 3 y	Trauma	6 versus 24 h	6 h, acceptable; 24 h, best	
Quandt et al ¹⁹	1984	20	24 y to 84 y	SICU	2 versus 24 h	2 h, acceptable	Nutrition must be kept constant
Record et al ²⁰	1984	13		Surgical	6 versus 24 h	6 h, acceptable	Infusion of calories must be kept constant
Sorkness ²³	1984	5		Trauma	4, 8, 12 versus 24 h	12 h, acceptable	If 10% error is deemed acceptable

* Publication of studies that examine the accuracy of shorter timed urine collections to their 24-h counterparts from various hospitalized patients under stress conditions.

Table 3. UUN versus TUN in hospitalized patients*

Authors/Ref. no.	Year	No. of Subjects	Subjects	Age	Comments
Steinhorn et al ²⁹	1985	48	ICU pediatrics	1 mo-18 y	61% postop day 1 73% postop day 2 87% postop day 3
Steinhorn and Radmer ²⁸	1986	25	ICU pediatrics	1 mo-18 y	41% liver failure, 35% sepsis, 48% postop, 44% overall
Grimble et al ²⁴	1988	104	Healthy; pre- and postsurgical	Adults	TPN 73% \pm 16; range 25-95% TEN 81% \pm 13; range, 57-109% Fasted 84% \pm 10; range, 74-100% Fed 87% \pm 9; range 74-100%
Loder et al ²⁷	1989	120	Pre- and postsurgical	Neonates	25% error postsurgical
Helms et al ³⁰	1991	Pre- and postsurgical	Neonates	57% \pm 4 postop day 1 40.6% \pm 16 postop day 2	
Akin	1991	25	ICU	72 h-4 wk	Range, 0.8-69.0%
Konstantinides et al ²⁵	1991	491	Trauma and postoperative		Overall, 80 \pm 12%; range, 12-112%
Moore et al ³¹	1991	99	BMT	Adults	Nitrogen balance range, 0.1-12 g Difference UUN versus TUN Urea acceptable in most patients after BMT
Konstantinides et al ²⁶	1992	27	Burn	Adults	63 \pm 12%
Boehm (personal communication)	1992	46	Neonates	Adults	47.2 \pm 16.2%
Boehm (personal communication)	1992	92	Critically ill	Pediatrics	62.5 \pm 21.9%

* Publication of studies that examine the validity of UUN against TUN in various populations of hospitalized patients under stress conditions. ICU, intensive care unit; Postop, postoperative; BMT, bone marrow transplantation.

urea production can be attributed to disease-specific causes such as cirrhosis or liver failure, in which less urea is produced from ammonia, the by-product of catabolism (amino acids).³³

Grimble et al²⁴ have summarized many metabolic alterations that could result in a lowered UUN/TUN ratio. The following is an excerpt from their report.

Several explanations may be suggested for low UUN/TUN. Total starvation³⁴ and chronic protein and energy restriction³⁵ result in conservation of nitrogen and a switch to ketones as a metabolic fuel.³⁶ Ureagenesis is depressed while ammonia excretion increases markedly, as a result of the need to titrate urinary ketone losses with NH_4^+ .³⁵ derived from glutamine.³⁷ Alterations in UUN/TUN, under these circumstances, are quite marked, in one study protein restriction reduced UUN/TUN to 68% after 8 day,³⁵ while 6 weeks' starvation caused UUN/TUN to fall to 33%.³⁴ In chronic acidosis, a similar pattern occurs due to increased renal uptake of glutamine.³⁸ Similar considerations would apply to the pattern of urine nitrogen excretion in the severely malnourished, acidotic, or cachexic patient. Although aminociduria accounts for only 0.5-2.5% of urine nitrogen,^{35,39} as with creatinine,³⁴ a decline in urea excretion will alter UUN/TUN markedly even though amino acid and creatinine excretion have not increased greatly.⁴⁰ Finally, where there is extensive catabolism of connective tissue, proline/hydroxyproline-containing peptides released are not reabsorbed by the kidney⁴¹ but can

appear in large quantities in the urine, and represent a not inconsiderable nitrogen loss.^{42,43}

Although urea production may be altered, measured UUN and other metabolic indices, as shown in Table 4,⁴⁴ can aid in determining stress levels and in prescribing and monitoring the protein and nutritional treatment regimen. UUN reflects the rate of muscle catabolism, that is, primary lean body mass. TUN reflects UUN and other by-products of the catabolism, which is both accelerated and occurs excessively in the hypermetabolic period accompanying stress.

Steinhorn et al found that urinary urea averaged only 45.7 \pm 0.6% of the measured TUN in intensive care unit pediatric patients during the first day of stress after a surgical procedure.²⁸ They also showed that liver failure and/or sepsis can alter urea production and invalidate the use of UUN in the same population.²⁹

Grimble et al also reported deviation from the normal 80% in both enteral and parenterally fed adult surgical patients during the first 3 days after surgery.²⁴ Patients receiving TPN had UUN/TUN ranging from 25% to 95% (72.7 \pm 15.8%). The enteral fed patients had UUN/TUN ratios ranging from 57% to 109% (80.5 \pm 13.3%). For meaningful comparison, two control groups were also included in the study. Group 1 fasted, and group 2 was fed. The UUN/TUN values for the two

Table 4. Categories of metabolic stress*

Stress	Concentration in Plasma (μ mol/L)					Concentration in Urine (μ mol/L)	
	Lactate†	Glucose‡	Leucine	Proline	Phenylalanine	Nitrogen (g/d)	3-Methyl Histidine
0	<1000	5.5 ± 2	120 ± 10	200 ± 20	60 ± 15	<5	<100
1	1200 ± 200	9.5 ± 1.4	74 ± 12	213 ± 4	74 ± 8	5-10	130 ± 20
2	1200 ± 200	9.5 ± 1.4	74 ± 12	13 ± 40	74 ± 8	10-15	200 ± 20
3	3000 ± 500	16 ± 1.6	180 ± 30	300 ± 50	124 ± 17	>15	450 ± 50

* Reproduced with permission from Konstantinides et al.²⁴

† In the presence of lactate/pyruvate, ratio less than 20.

‡ In the absence of steroid therapy, diabetes mellitus, or pancreatitis.

groups were $87.0 \pm 9.3\%$ and $84.0 \pm 10.2\%$, respectively, with moderately varying ranges of 74% to 100% in group 1 and 70% to 100% in group 2.

Ward and colleagues⁴⁵ examined the effects of nitrogen delivery comparing the route of delivery in general surgical patients and found results similar to those of Grimble et al.⁴⁶ In their population, Ward et al observed that TPN-fed patients had a mean UUN/TUN of 87% (range, 30% to 90%), whereas the TEN patients had a mean UUN/TUN of 83.8% (range, 55% to 100%).

Loder et al focused on the relationship between UUN and TUN in preoperative, postoperative, and critically ill patients.²⁷ In their study, UUN and TUN were closely related in preoperative patients. Postoperative and stressed patients exhibited UUN/TUN inconsistencies within each group, producing unreliable estimates of the nonurea nitrogen excretion from individual patients.

Heims and colleagues⁴⁶ recently conducted a study of postsurgical, preterm neonates receiving parenteral nutrition. They concluded that TUN assessment of nitrogen loss is a more accurate method for evaluating nitrogen balance. They based their reasoning on the fact that UUN assessment was associated with wide intrapatient and interpatient variability leading to a significant underestimation of nitrogen loss.

Konstantinides et al retrospectively studied the relationship between UUN and TUN in stressed patients, most commonly surgical or trauma patients.²⁵ Samples were collected and studied over a range of 1 to 10 days after the stressful event had occurred. The population studied was composed of members from each sex who were not insulin-dependent diabetics or cirrhotic and who displayed an adequate glomerular filtration rate (creatinine clearance > 25 mL/min). Four hundred ninety-one UUN/TUN paired studies were performed with measured TUN outputs ranging from 0.04 to 54.0 g/d. The UUN/TUN ratio for the entire population was $80.0 \pm 12.0\%$. In this patient population, the range varied from 12 to 112% (Fig 1). Data from 315 nitrogen balance studies were used to compare nitrogen balance determined by using UUN as an estimate of TUN (corrected by 1.25 [times] UUN) with those calculated directly from measured TUN. The difference between these two groups was 1.85 ± 1.69 g,

with a range of 0.01 to 12.31 g (Fig 2). Only the parenteral route of administration of nutrition was used in this study. When results for UUN/TUN were examined for the effect of nitrogen input, there appeared to be an upward trend in urea production as nitrogen input was increased but no statistically significant differences were found. Similar results were found for the nitrogen balance studies.

There is little difference in UUN/TUN or nitrogen balance at the lower end of TUN output or low stress level. There is a progressively increasing difference in the UUN/TUN and likewise nitrogen balance as the TUN output or the degree of stress increases.

PYROCHEMILUMINESCENCE™

The Kjeldahl procedure is the most widely used method for measuring nitrogen in analytical chemistry. Application of this method for measuring TUN in supportive nutrition assessment has been criticized as being costly, hazardous, and time consuming. Today, the current micro-Kjeldahl method is safer than the older technology, and although it is expensive and slow, it remains in many clinical laboratories for measuring TUN. Pyrochemiluminescence (PCL) (Antek Instruments Inc, Houston, TX) has been proposed as an

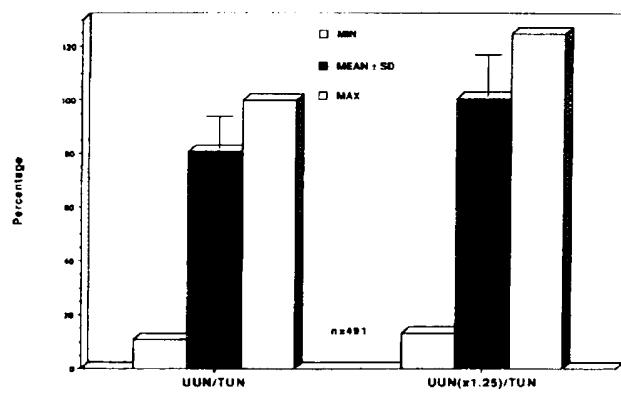


Figure 1. Comparison of UUN/TUN ratios and corrected UUN/TUN ratios for nonurea nitrogen components. Reproduced with permission from Konstantinides et al.²⁵

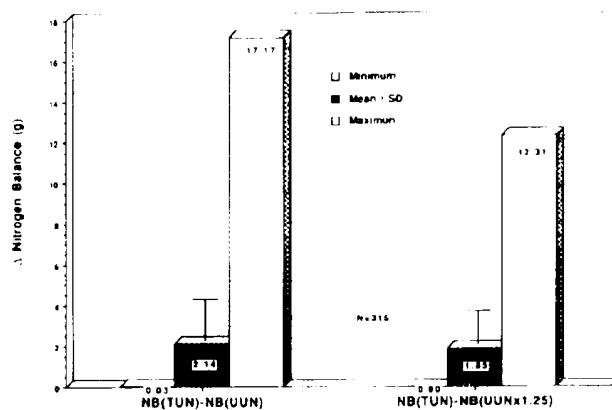


Figure 2. Change in nitrogen balance (NB), expressed in grams, calculated from NB using TUN, UUN, and estimated TUN (as UUN x 1.25). Reproduced with permission from Konstantinides et al.²³

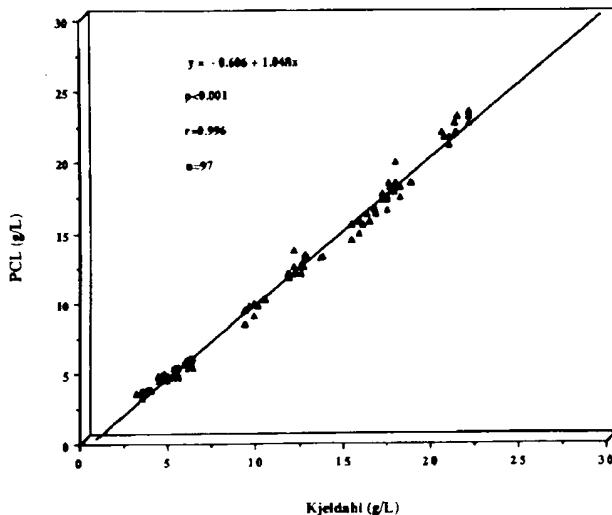


Figure 3. Regression analysis of PCL versus Kjeldahl for TUN determinations for 24-hour urine collections over entire range measured: $r = .996$; $r' = .992$; $n = 97$; $y = 2.048 x - 0.606$ ($P < .001$). Reproduced with permission from Konstantinides et al.¹⁷

alternative to the Kjeldahl method for TUN measurement in support of nutrition assessment in clinical laboratories. PCL was first used in 1977 in the petrochemical industry to determine the nitrogen content of petroleum products. Shortly thereafter, Ward et al, using a modified chemiluminescence analyzer, were able to adapt the concepts to measure nitrogen in biological fluids. Konstantinides et al compared the time and cost effectiveness of TUN analysis by PCL versus traditional Kjeldahl techniques as well as the linear regression between the two methods.¹⁷ The results suggest a significant savings in both time and cost

by PCL, with an excellent regression between urine samples analyzed by both methods (Fig 3). Many investigators have studied the relationship between biological samples measured by micro- and macro-Kjeldahl methods versus PCL and have concluded that PCL is a cost-effective alternative in determining nitrogen content^{24,25,45,47-52} (Table 5). It is now well established that PCL can replace the Kjeldahl procedure in clinical laboratories when TUNs are performed for nitrogen balance determinations in the clinical setting.

CREATININE-HEIGHT INDEX

Creatinine is a component of urine nitrogen that is a waste product of creatine. The formation of creatinine is constant and represents 1.7% to 2.0% of the creatine produced. Creatinine is also a by-product of phosphocreatine, a high-energy phosphate formed by creatine that is used in muscle metabolism.⁵³ In 1976, Forbes and Bruining investigated the relationship between urinary creatinine and lean body mass.⁵⁴ Their subjects were 13 short-statured children and 21 normal adults. None of the subjects were receiving medications or had any evidence of urinary tract disease. Three 24-hour urine collections were made for each subject. Lean body mass was plotted against average creatinine with a correlation coefficient of 0.988. Forbes and Bruining concluded that urinary creatinine excretion may serve as a reasonable index of lean body mass in subjects without dietary restrictions.

A similar study, conducted by Heymsfield et al, reached the same conclusions but with added stipulations.⁵⁵ First, changes from a creatinine-free diet to a meat diet and vice versa cause changes in the amount of creatine and, hence, urinary creatinine excretion. Variability in creatinine excretion also can be attributed to normal daily variation, severe emotional stress, vigorous exercise, different phases of the menstrual cycle, severe renal insufficiency, and severe illness. It was concluded that the use of creatinine as an index of muscle mass should serve only as an approximation. These qualifications limit the usefulness of creatinine excretion to a select group of individuals.

The assessment of urinary creatinine is often accompanied by the use of the creatinine-height index. Creatinine-height index is the 24-hour creatinine excretion of the patient divided by the expected 24-hour creatinine excretion of a normal adult of the same height. It is the ratio between observed and expected urinary creatinine values. Expected creatinine is calculated by finding the expected creatinine level of a well-nourished person based on height. Supplements to the patient's nutritional program may be made accordingly.

In 1970, Viteri and Alvarado studied the accuracy of the creatinine-height index in the estimation of protein status in malnourished children.⁵⁶ Several children classified as having edematous protein calorie malnu-

Table 5. Pyrochemiluminescence (PCL) versus Kjeldahl for biological samples*

Author/Ref no.	Journal	Year	Experiment	Sample	Conclusion
Ward et al ⁴⁵	Clin Chem	1980	PCL versus Kjeldahl	Biological	$r = 0.99, 0.96, 0.72$; PCL acceptable
Drummond et al ⁴⁸	JPEN	1986	PCL versus Kjeldahl	Urinary nitrogen	$r = 0.97$; PCL acceptable
Grimble et al ²⁴	JPEN	1988	PCL versus Kjeldahl	Fecal and urinary	Fecal $r = 0.96$; PCL acceptable
Konstantinides et al ⁴⁷	Clin Chem	1988	PCL versus Kjeldahl	Urine	$r = 0.996$; PCL acceptable
Konstantinides et al ¹⁵	JPEN	1989	PCL versus Kjeldahl	Urine	$r = 0.996$; PCL acceptable
Konstantinides	ESPEN	1989	PCL versus Kjeldahl	Urine	$F = 0.482, P = 0.695$; multicenter comparison shows no difference
Dechert et al ⁵⁰	JPEN	1990	PCL versus Kjeldahl	Urine	$r = 0.97$; PCL acceptable
Skogerboe et al ⁵¹	Clin Chem	1989	PCL versus Kjeldahl	Homogenized food or stool	$r = 0.999, 0.998$; PCL acceptable
Skogerboe et al ⁵²	Clin Chem	1990	PCL versus Kjeldahl for TUN	Urine	$r = 0.975$; PCL acceptable

* Publication/presentations of studies that examine the validity of PCL against Kjeldahl methods for measuring nitrogen levels in various biological samples.

trition and nonedematous protein calorie malnutrition were kept under careful pediatric care. Twenty-four hour urine samples were collected when adequate urinary flow had been established. The children received a strict diet, with 20% of the calories derived from fat in milk and vegetable oil and the rest provided by protein, sucrose, dextromaltose, and starch. It was concluded that the creatinine-height index accurately reflected the degree of protein depletion and repletion in the hospitalized children. A main limitation was the preferred requirement of a 72-hour urine collection.

Bistrian et al also studied nutritional depletion in hospitalized patients.⁵⁶ The creatinine-height index was calculated for 30 young, adult male students who were fed meat-free diets that supplied adequate protein. This was compared with the creatinine-height index of 11 malnourished male surgical patients. The mean creatinine-height index was 1.09 in the young, adult males and 0.50 in the malnourished surgical patients. Bistrian et al concluded that these results suggest a role for the creatinine-height index in the nutrition assessment of the surgical patient.

SUMMARY

Nitrogen balance studies play an important role in the nutrition and metabolic management of hospital patients. Nitrogen excretion can be effectively measured using urine kept on ice or at room temperature, with or without preservatives. Twenty-four-hour urine collections are preferred rather than those of shorter duration. Urine is analyzed for UUN or TUN, although TUN offers more advantages.

Under nonstressed conditions, urea composes 80%

to 90% of TUN but, with increased stress in a variety of age groups, has been found to vary from 10% to 90%. Nitrogen excretion calculated from UUN is affected by increased stress, which can alter urea production and/or increase nonurea nitrogen by-products. Therefore, TUN results are consistently more reliable. Because the technology is available to quantify TUN by PCL, it remains the preferred method of urinary nitrogen excretion determination for hospitalized patients, especially those with increased stress.

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